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IN THE

Supreme Court of the United States

ABIGAIL NOEL FISHER,

Petitioner,

v.

UNIVERSITY OF TEXAS AT AUSTIN, et al.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR AMICI CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ET AL. IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

INTEREST OF AMICI CURIAE 1

SUMMARY OF THE ARGUMENT 3

ARGUMENT 7

I. DIVERSITY IS A VITAL COMPONENT OF THE EDUCATIONAL MISSION OF THE NATION'S MEDICAL SCHOOLS 7

A. Physicians Must Understand How To Serve Diverse Communities 7

B. The Benefits Of Diversity Are Indispensable To Achieving Core Educational Goals 13

II. MEDICAL SCHOOLS HAVE LONG RELIED ON HOLISTIC REVIEW FOR ADMISSIONS DECISIONS 23

A. Medical Schools Have A History Of Highly-Individualized Admissions Practices 24

B. Although Other Initiatives Have Shown Some Success, It Remains Necessary For Medical Schools To Consider Applicants' Full Backgrounds In Order To Achieve The Schools' Educational Goals 29

TABLE OF CONTENTS—Continued

Page

III. PRECLUDING OR LIMITING HOLISTIC REVIEW WOULD DISRUPT ADMISSIONS PRACTICES CRAFTED IN RELIANCE UPON THE COURT'S PRECEDENTS 34

CONCLUSION 38

ADDENDUM

TABLE OF AUTHORITIES

Page(s)

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BRIEF FOR AMICI CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ET AL. IN SUPPORT OF RESPONDENTS

INTEREST OF AMICI CURIAE

The **Association of American Medical Colleges** ("AAMC") is a non-profit educational association whose members include all 145 accredited U.S. medical schools; the 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and 90 academic and scientific societies.[1] Through these institutions

[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution

and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians. Founded in 1876, the AAMC, through its many programs and services, strengthens the world's most advanced medical care by supporting the entire spectrum of education, research, and patient care activities conducted by its member institutions.

AAMC is joined in this brief by twelve organizations whose members include schools, residency programs, and other institutions involved in educating and training health care providers and administrators: the **American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Associated Medical Schools of New York, Association of Academic Health Centers, Association of American Veterinary Medical Colleges, Association of Schools and Programs of Public Health, Association of Schools of Allied Health Professions, Association of University Programs in Health Administration, National Association of Hispanic-Serving Health Professions Schools, Inc.**, and the **Physician Assistant Education Association** ("PAEA"); fifteen organizations whose members include physicians and other health care providers: the **American Medical Association, American Dental Association, American Nurses**

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intended to fund the preparation or submission of this brief. No person other than the amici curiae or their counsel made a monetary contribution to its preparation or submission. The parties have consented to the filing of this brief.

Association, American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Physician Assistants, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, American Psychiatric Association, American Public Health Association, Association of American Indian Physicians, National Hispanic Medical Association, National Medical Association, and the **Society of General Internal Medicine**; three organizations that represent the interests of medical school students: the **American Medical Student Association, National Medical Fellowships, Inc.**, and the **Student National Medical Association**; and two non-profit organizations dedicated to improving health care in Puerto Rican, Latino, and Hispanic communities: **The ASPIRA Association, Inc.**, and the **National Hispanic Health Foundation**. Additional information regarding these organizations is provided in the Addendum to this brief.

SUMMARY OF THE ARGUMENT

At its best, the quality of medical care in the United States is unmatched throughout the world, in large part because of its unparalleled medical education institutions. As the gatekeepers to the medical profession, medical schools have obligations that extend beyond their individual students to society at large. Those obligations include redressing current disparities in health care, where minority patients tend to receive less and lower quality care. The Nation's medical schools must ensure not only that graduating physicians will be able to practice medicine at the highest levels, but also that

competent medical care in different practice areas will reasonably be available to all who need it.

Medical schools have learned over many decades of experience that these goals cannot be accomplished unless physicians are educated in environments that reflect the ever-increasing diversity of the society they serve. As a result, access to medical education has never been determined solely by metrics such as test scores and grades. Rather, admission has historically been based on a holistic evaluation process—including personal interviews—in which an applicant's background is taken into account along with myriad other factors.

In 2012, the AAMC, alongside 29 other organizations involved with the education of physicians and other health professionals, submitted a brief to the Court in this case, describing the importance of student diversity in health professional educational settings and the continued need, in the context of selecting a student body to achieve an educational institution's mission, to consider race and ethnicity among other factors in the admissions process. Those needs have not changed. Nor has the responsibility given to educational institutions to prepare physicians and other health professionals to care for all Americans.

In *Regents of the University of California* v. *Bakke*, 438 U.S. 265 (1978), the Court approved of this holistic evaluation process, with Justice Powell providing the deciding rationale. As he explained:

> Physicians serve a heterogeneous population. An otherwise qualified medical student with a particular background—whether it be ethnic, geographic, culturally advantaged or disadvan-

> taged—may bring to a professional school of medicine experiences, outlooks, and ideas that enrich the training of its student body and better equip its graduates to render with understanding their vital service to humanity.

Id. at 314 (Powell, J.). Twenty-five years later, the Court specifically endorsed Justice Powell's rationale, after observing that "[p]ublic and private universities across the Nation have modeled their own admissions programs on Justice Powell's views." *Grutter* v. *Bollinger*, 539 U.S. 306, 323 (2003); *see also id.* at 387 (Kennedy, J., dissenting) ("The opinion by Justice Powell, in my view, states the correct rule for resolving this case.").

Justice Powell's words ring as true today as they did thirty-seven years ago. Indeed, the need to train the next generation of physicians in a diverse educational environment is even more important now, as our society has become even more heterogeneous. Research shows that when physicians understand more about the diverse cultures of their patients, physician decision-making is better informed and medical outcomes improve. Thus, preventing medical educators from continuing to consider diversity would not merely impoverish the educational experience of all future doctors; it would diminish their ability "to render with understanding their vital service to humanity." *Bakke*, 438 U.S. at 314 (Powell, J.).

In the thirty-seven years since *Bakke*, medical schools throughout the Nation have been implementing and refining holistic methods for evaluating applicants of the type approved by Justice Powell and later endorsed by the Court. In evaluating an applicant's ability to contribute to and

benefit from an enriching educational environment, race is considered merely as one of a multitude of factors, none of which is dispositive standing alone. Although test scores and grades are a significant barometer of merit, they have never been independently determinative in medical school admissions. The goal is not mechanically to admit students based on numerical criteria or to mirror the country's demographics, but rather to produce a class of physicians best equipped to serve *all* of society.

There is no proven substitute for this individualized, holistic review that may consider an applicant's race and ethnicity along with all other factors that make up his or her background. As this Court recognized in *Grutter*, 539 U.S. at 340, for medical schools and other graduate institutions there is nothing akin to the State's "Top 10%" plan, which achieves a degree of diversity only because of underlying residential segregation in Texas. Health professional educators have found no other proxy that could substitute for individualized consideration of an applicant's entire background.

Dating to *Bakke* and continuing through *Grutter*, the Nation's medical schools have relied on this Court's approval of the legal framework supporting their holistic, individualized evaluation process, which furthers the schools' societal obligation to ensure that physicians will be competent to serve their increasingly diverse patients. Overruling the judgment of these expert educators would effectively prevent medical schools from fully carrying out that obligation, to the detriment of patient health. Accordingly, amici urge this Court to take no action that would disrupt the admissions processes that

have been carefully crafted in reliance on these longstanding precedents.

ARGUMENT

I. DIVERSITY IS A VITAL COMPONENT OF THE EDUCATIONAL MISSION OF THE NATION'S MEDICAL SCHOOLS.

A. Physicians Must Understand How To Serve Diverse Communities.

The current picture of health in America is simultaneously bright and bleak. While we are better equipped than ever with biomedical knowledge and technology to both avoid disease and prevent early death, certain segments of the population have been slow to benefit from these advancements.

Significant health disparities exist along lines of socio-economic status, urban or rural residence, and, most notably, race and ethnicity. *See* Bruce G. Link, *Epidemiological Sociology and the Social Shaping of Population Health*, 49 J. of Health & Soc. Behav. 367 (2008). Minority populations continue to disproportionately suffer from numerous health conditions. Non-Hispanic black adults, for example, are at least 50% more likely to die prematurely (i.e., before age 75) of heart disease or stroke than their non-Hispanic white counterparts. The prevalence of adult diabetes is higher among Hispanics, non-Hispanic blacks, and those of other or mixed races than among Asians and non-Hispanic whites. And the infant mortality rate for non-Hispanic blacks is more than double that for non-Hispanic whites. *See* Ctrs. for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report—United States, 2013*, 62 MMWR (Supp.) No. 3, at 101, 158, 172 (Nov. 22, 2013) (www.cdc.gov/mmwr/pdf/other/su6203.pdf).

Despite lower rates of uninsured individuals, "disparities in quality and outcomes by income and race and ethnicity are large and persistent." U.S. Dep't of Health & Human Servs. ("HHS"), Agency for Healthcare Research & Quality, *2014 National Healthcare Quality and Disparities Report*, at 2 (2015) (www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf). When new technologies emerge to fight disease, minorities experience substantially slower and fewer benefits than non-minorities. *See* Link, *supra*. While some of these disparities are due to lower levels of health care in minority communities, the disparities persist even where access is universal, such as in veterans' care. *See* Heena P. Santry & Sherry M. Wren, *The Role of Unconscious Bias in Surgical Safety and Outcomes*, 92 Surg. Clin. N. Am. 137 (2012).

Moreover, minority communities are both medically underserved and served disproportionately by physicians of their own race or ethnicity. Communities with high proportions of African-American and Hispanic residents are far more likely to have a physician shortage, regardless of income levels. *See, e.g.*, Joel S. Weissman et al., *Residents' Preferences and Preparation for Caring for Underserved Populations*, 78 J. Urban Health 535 (2001); *see also* Kara Odom Walker et al., *The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties*, 104 J. Nat'l Med. Ass'n 46 (2012). Underserved residents also rely heavily on underrepresented minority physicians for their care, because relatively few non-minority physicians practice in those areas. *See* Somnath Saha & Scott A. Shipman, *Race-Neutral Versus Race-Conscious Workforce Policy To*

Improve Access To Care, 27 Health Aff. 234 (2008); William T. Basco Jr. et al., *Assessing Trends in Practice Demographics of Underrepresented Minority Pediatricians, 1993–2007*, 125 Pediatrics 460 (2010).

African-American and Hispanic/Latino medical school graduates are more likely than their white and Asian counterparts to consider serving underserved communities. A recent study revealed that, by the time of graduation, 56% of African-American and 42% of Hispanic/Latino students were willing to serve the underserved as compared with only 21% of Asian and 23% of white students. Douglas Grbic & Franc Slapar, *Changes in Medical Students' Intentions to Serve the Underserved: Matriculation to Graduation*, 9 Analysis in Brief No. 8, at 2 (AAMC July 2010). A recent Senate Report reached the similar conclusion that "[d]iversity among medical school students is associated with * * * greater willingness to serve diverse populations," and found evidence to suggest that "minority health professionals are more likely to serve in areas with high rates of uninsured and areas of underrepresented racial and ethnic groups." S. Rep. No. 114-74, at 42 (2015).

At the same time, it is estimated that by 2025, there will be a shortage of between 46,000-90,000 physicians in the U.S. *See* AAMC, *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025*, at v (2015) (https://www.aamc.org/download/426242/data/ihsreportdownload.pdf). Physician assistants and nurse practitioners are playing an increasing role in the health professions workforce and are helping to improve access to care. In 2014, the number of entering medical school students that identified as Black or African-American, Hispanic or Latino, or American Indian or

Alaska Native was 12.3%. AAMC, *Applicants, First-Time Applicants, Acceptees, and Matriculants to U.S. Medical Schools by Race/Ethnicity, 2013-2014 and 2014-2015*, at 2 (2014) (www.aamc.org/download/321480/data/factstable12.pdf) (table 12). As of fall 2014, approximately 22% of nursing students enrolled across program levels were underrepresented minorities. *See* Am. Ass'n of Colls. of Nursing ("AACN"), *2014-2015 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing* (2015) (table 9). In 2014, less than 4% of physician assistant matriculants identified as Black or African-American or American Indian or Alaskan Native, and 6% self-identified as Hispanic, Latino, or Spanish. *See* PAEA, *By the Numbers: Matriculating Students Survey 2014*, at 21 (May 2015) (table 39). Among recently certified physician assistants, less than 4% self-identified as Black or African-American or American Indian or Alaskan Native, and 7% self-identified as Hispanic, Latino, or Spanish. *See* Nat'l Comm'n on Certification of Physician Assistants, *2014 Statistical Profile of Recently Certified Physician Assistants*, at 10 (2015) (tables 4 & 5).

In contrast, Non-Hispanic Black or African-American, Non-Hispanic American Indian or Alaska Native, and Hispanic or Latino people constitute 30.5% of the total U.S. population, with that number expected to increase.[2] It is therefore plain that

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[2] This calculation is based on data from the U.S. Census as of July 1, 2014. *See* U.S. Census Bureau, *American FactFinder* (factfinder.census.gov/faces/nav/jsf/pages/index.xhtml); *see also* William H. Frey, *America's Diverse Future: Initial Glimpses at the U.S. Child Population from the 2010 Census* (Brookings 2011) (http://www.brookings.edu/~/media/research/files/papers/2011/4/06-census-diversity-frey/0406_census_diversity_frey.pdf); Laura B. Shrestha & Elayne J. Heisler, *The Changing*

health professionals of *all* races and ethnicities must learn to better serve the country's diverse patient population in order to reduce disparities in health outcomes. *See* AMA Code of Medical Ethics, Op. 9.121, *Racial and Ethnic Health Care Disparities* (calling on physicians to recognize and reduce racial and ethnic disparities in health care).

The Nation's medical schools and other health professional schools believe that a key component of a comprehensive strategy to eliminate the health disparities described above is to develop a workforce of people from all backgrounds to bridge the current differences between providers and patients. In addition to graduating physicians with the highest medical skills, medical schools also seek to train physicians with high levels of "cultural competence." These are physicians who are familiar with the connection between socio-cultural factors and health beliefs and behaviors and who have the tools and skills to manage these factors appropriately to help eliminate socio-cultural barriers to care. *See* Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 Pub. Health Rep. 293, 297–300 (2003).

Nursing programs across the country have also placed greater emphasis on educating a culturally competent workforce. The objective is to educate and train students to provide patient-centered care that identifies, respects, and addresses differences in patients' values, preferences, and expressed needs. *See* AACN, *Cultural Competency in Baccalaureate*

Demographic Profile of the United States 18–23 (Cong. Research Serv., Mar. 31, 2011).

Nursing Education (2008) (www.aacn.nche.edu/leading-initiatives/education-resources/competency.pdf); AACN, *Establishing a Culturally Competent Master's and Doctorally Prepared Nursing Workforce* (2009) (www.aacn.nche.edu/education-resources/CulturalComp.pdf). These efforts further the profession's objective of eliminating health disparities that nurses must address in a global environment, in partnership with other health care disciplines. *See* HHS, Nat'l Comm. on Vital & Health Stats., 2005, *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Primary Language in the United States* (2005) (www.cdc.gov/nchs/data/misc/EliHealthDisp.pdf).

Medical schools strongly believe that diversity in the educational environment is integral to instilling in new physicians the cultural competence necessary to more effectively serve a diverse society. They are committed to creating a diverse educational environment because they believe that a diverse student body produces educational outcomes that ultimately benefit public health. "[M]uch of the point of education is to teach students how others think and to help them understand different points of view—to teach students how to be sovereign, responsible, and informed citizens in a heterogeneous democracy." Akhil Reed Amar & Neal Kumar Katyal, Bakke*'s Fate*, 43 UCLA L. Rev. 1745, 1774 (1996). For medical schools, the educational benefits of diversity are fundamentally necessary to improve health outcomes throughout the United States. A diverse classroom "provide[s] a unique contribution to learning, discussion, and understanding that is not necessarily attainable elsewhere." Lisa A. Tedesco, *The Role of Diversity in the Training of*

Health Professionals, in *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions* 36, 50 (Inst. of Med. 2001). And opportunities for students to be mentored by diverse medical leaders significantly enhance the learning environment. *See* David A. Thomas, *The Truth About Mentoring Minorities: Race Matters*, 79 Harv. Bus. Rev. 98 (2001).

Just as Justice Powell recognized more than three decades ago, amici remain convinced that because "[p]hysicians serve a heterogeneous population" they must be educated in a medical school that includes students of *all* backgrounds, who bring "experiences, outlooks, and ideas that enrich the training of its student body and better equip its graduates to render with understanding their vital service to humanity." *Bakke*, 438 U.S. at 314 (Powell, J.). As discussed further below, medical schools continue to carry out that societal obligation by employing the holistic admissions process approved by Justice Powell and later endorsed by the Court, which properly considers an applicant's entire background without predetermined quotas or outcomes.

B. The Benefits Of Diversity Are Indispensable To Achieving Core Educational Goals.

Diversity in medical school admissions is not an end in itself, but rather a means to achieving core educational goals defined by the institution. *See* Amy N. Addams et al., *Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes*, at ix (AAMC 2010) (https://members.aamc.org/eweb/upload/Roadmap%20to%20Diversity%20Integrating%20Holistic%20Review.pdf). While diversity may include race, ethnicity,

and gender, it is a "student-specific, multi-dimensional concept" that "may encompass other dimensions of experiences and attributes" including, among other things, an applicant's having overcome hardships or cultural barriers, languages spoken, socioeconomic status, and geography. *Id.*

This flexibility means that diversity is not a "one-size-fits-all" concept. Just as it can encompass a variety of factors within a single school, it may have different meanings from one school to the next. Depending on the "institutional mission, educational goals, the kind of students a medical school wants to educate, and the kind of physicians it wants to graduate," the diversity interests of one medical school may be markedly different from those of another. *Id.* While their practices will likely share common elements, each school must determine how best to apply diversity principles in pursuing its institutional goals. "The key to success for any medical school seeking to enroll and graduate a broadly diverse class is the connection the school makes between the diversity it seeks and the *educational, mission-driven* goals to which it aspires." Arthur L. Coleman et al., *Roadmap to Diversity and Educational Excellence: Key Legal and Educational Policy Foundations for Medical Schools*, at vii (AAMC 2d ed. 2014) (https://members.aamc.org/eweb/upload/14-050%20Roadmap%20to%20Diversity_2nd%20ed_FINAL.pdf) (incorporating guidance based on the *Fisher I* decision) (emphasis in original).

For most medical schools, these goals include producing culturally-competent physicians who are well-adapted to serve patients from across the varied racial and ethnic makeup of the Nation. As this Court recognized in *Grutter*, "numerous studies show

that student body diversity promotes learning outcomes, and 'better prepares students for an increasingly diverse workforce and society, and better prepares them as professionals.'" 539 U.S. at 330 (citation omitted).

In the medical education environment, these benefits are particularly important because public health is at stake, not just business interests. A diverse student body helps to promote the empathy, emotional intelligence, and cultural competence required of physicians and other health care professionals. Medical students who are educated in a diverse student body report that they are better able to work with patients of diverse backgrounds. Gretchen Guiton et al., *Student Body Diversity: Relationship to Medical Students' Experiences and Attitudes*, 82 Acad. Med. S1, S1 (Oct. 2007 Supp.); *see also* Somnath Saha et al., *Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools*, 300 JAMA 1135, 1135 (2008) (finding that non-minority students attending more racially diverse medical schools exhibited greater preparedness to care for minority patients and stronger attitudes about equitable access to health care). The benefits are even greater when students engage in informal discussions about course materials with peers from diverse backgrounds, *see* Guiton, *supra*, at S4, and when medical schools actively promote student engagement and perspective-sharing across diverse backgrounds, *see* Saha et al., *supra*, at 1141. *See also* Emory Morrison & Douglas Grbic, *Dimensions of Diversity and Perception of Having Learned From Individuals From Different Backgrounds: The Particular Importance of Racial Diversity*, 90 Acad. Med. 937

(2015) (graduating students associated racial/ethnic diversity within medical school class with greater ability to work with individuals from different backgrounds).

One contributor to health disparities is unconscious bias by physicians. Studies have shown that this bias exists and negatively impacts clinical decision making, which leads to negative treatment decisions and outcomes.[3] There is also a connection between the unconscious bias of the physician and the patient's negative response to that behavior. *See* Lisa A. Cooper et al., *The Associations of Clinicians' Implicit Attitudes about Race with Medical Visit Communication and Patient Ratings of Interpersonal Care*, 102 Am. J. Pub. Health 979 (2012).

In its *Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree*, the Liaison Committee on Medical Education ("LCME") evaluates whether the medical school curriculum "provides opportunities for medical students to learn

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[3] *See, e.g.*, Santry & Wren, *supra*; Alexander R. Green et al., *Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. Gen. Internal Med. 1231 (2007); Janice A. Sabin et al., *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. Health Care for Poor & Underserved 896 (2009); Laura M. Bogart et al., *Factors Influencing Physicians' Judgments of Adherence and Treatment Decisions for Patients with HIV Disease*, 21 Med. Decision Making 28 (2001); Michelle van Ryn et al., *Physicians' Perceptions of Patients' Social and Behavioral Characteristics and Race Disparities in Treatment Recommendations for Men With Coronary Artery Disease*, 96 Am. J. Pub. Health 351 (2006); Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients*, 50 Soc. Sci. & Med. 813 (2000).

to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process." LCME, *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree* ("*Standards for Accreditation*"), at 11 (2015) (Standard 7.6) (www.lcme.org/publications.htm). Only by producing a workforce of health care professionals who are well-adapted to working in a diverse environment, with patients from all backgrounds, can health professional schools hope to alleviate some of these disparities in patient care.

Increased exposure to diverse perspectives may also increase an individual's ability to understand, accept, and ultimately value disparate viewpoints. Research among college students indicates that this ability can increase after engaging in even a single discussion with an individual expressing a minority viewpoint. *See* Anthony Lising Antonio et al., *Effects of Racial Diversity on Complex Thinking in College Students*, 15 Psychol. Sci. 507 (2004). And prolonged exposure to diverse viewpoints may have a cumulatively stronger impact on complex thinking skills. *Id.* at 509. For a physician or other health professional attempting to properly diagnose and design treatment plans for patients with different cultures, backgrounds, belief systems, and support networks, the ability to consider and integrate other perspectives is an essential skill.

In turn, the ability to work with individuals having diverse perspectives can improve outcomes. Studies have indicated that groups of people with diverse backgrounds and ways of viewing the world outperform groups of people who have similar backgrounds and perspectives, even when the latter group is

composed of those deemed to be the best individual performers. *See* Scott E. Page, *The Difference: How the Power of Diversity Creates Better Groups, Firms, Schools, and Societies* (2007). In the health care arena, "[d]iverse teams working together and capitalizing on individuality and distinct perspectives outperform homogenous teams. This is particularly true when teams address complex problems, such as those that characterize biomedical and behavioral research, technology, and health." Nat'l Insts. of Health ("NIH"), *Draft Report of the Advisory Committee to the Director Working Group on Diversity in the Biomedical Research Workforce* ("*NIH Draft Report*"), at 11 (2012) (acd.od.nih.gov/Diversity%20in%20the%20Biomedical%20Research%20Workforce%20Report.pdf) (citing Lu Hong & Scott E. Page, *Groups of Diverse Problem Solvers Can Outperform Groups of High-Ability Problem Solvers*, 101 Proc. Nat'l Acad. Sci. USA 16385 (2004); Valerie I. Sessa & Jodi J. Taylor, *Executive Selection: Strategies for Success* (Ctr. for Creative Leadership 2000)).

To capture the proven benefits of team-based, patient-centered care using a team of professionals with diverse perspectives, medical schools increasingly require students to work in teams and train alongside students in other fields. This interprofessional education can help future health care providers learn to work in a collaborative environment that considers all aspects of health, lifestyle, and background to provide the best patient care. Similarly, medical school students whose classmates represent diverse perspectives will be more prepared and capable of working collaboratively alongside others with diverse perspectives. "A workforce that brings the full power of diversity to pursue

biomedical and behavioral research problems that address the needs of underrepresented racial and ethnic minorities is an important component of reducing these health inequities." *NIH Draft Report*, *supra*, at 11 (citing David M. Stoff et al., *Introduction: The Case for Diversity in Research on Mental Health and HIV/AIDS*, 99 Am. J. Pub. Health S8 (Supp. 1 2009)). As indicated by a former Surgeon General, "a diverse team of researchers will be more likely to ask and pursue the most appropriate questions in the most appropriate manner—whether in basic and clinical research, or in health services[] and behavioral research." *Id.* (citing David Satcher, *Embracing Culture, Enhancing Diversity, and Strengthening Research*, 99 Am. J. Pub. Health S4 (Supp. 1 2009)).

To select candidates embodying these diverse viewpoints, medical schools consider factors that can include rural or urban backgrounds, bachelor's degrees in the sciences or liberal arts, unusual life experiences or journeys, and disparate racial and economic backgrounds, among others. A richly diverse class can contribute to a dynamic, multi-dimensional educational environment where classroom and study-group discussions add insight and texture to course materials.

These benefits have been recognized in nursing as well. Researchers with the Health Resources and Services Administration of the U.S. Department of Health and Human Services have explicitly identified "nursing workforce diversity as a key strategy for increasing access to quality health care and health-care resources." Shanita D. Williams et al., *Using Social Determinants of Health to Link Health Workforce Diversity, Care Quality and Access*,

and Health Disparities to Achieve Health Equity in Nursing, 129 Pub. Health Rep. 32, 33 (2014 Supp. 2).

These benefits of diversity in health professional education have been recognized by Congress, *see* Disadvantaged Minority Health Improvement Act of 1990, Pub. L. No. 101-527, § 1(b)(12), 104 Stat. 2311, 2312 (1990) (finding that "diversity in the faculty and student body of health professions schools enhances the quality of education for all students attending the schools"); by students, *see, e.g.*, Dean K. Whitla et al., *Educational Benefits of Diversity in Medical School: A Survey of Students*, 78 Acad. Med. 460, 466 (2003) (medical school students overwhelmingly reported that contacts with diverse peers greatly enhanced their educational experiences); and by faculty, *see, e.g.*, Robert A. Witzburg & Henry M. Sondheimer, *Holistic Review—Shaping the Medical Profession One Applicant at a Time*, 368 New Eng. J. Med. 1565, 1567 (Apr. 25, 2013) (according to medical school faculty, students selected through holistic review are "more collegial, more supportive of one another, more engaged in the curriculum, and more open to new ideas and to perspectives different from their own"). "[I]t is not too much to say that the 'nation's future depends upon leaders trained through wide exposure' to the ideas and mores of students as diverse as this Nation of many peoples." *Bakke*, 438 U.S. at 313 (Powell, J.) (citation omitted).

Efforts to promote the inclusion of racial and ethnic minorities are vital to the educational goals of medical and other health professional schools. Amici have concluded that a diverse educational environment is essential to addressing the health care needs of an increasingly diverse population. This educational judgment warrants deference. *See*

Fisher v. *Univ. of Tex.*, 133 S. Ct. 2411, 2419 (2013) ("*Grutter* calls for deference to the University's conclusion, 'based on its experience and expertise,' that a diverse student body would serve its educational goals.") (citation omitted); *Grutter*, 539 U.S. at 328 ("The Law School's educational judgment that such diversity is essential to its educational mission is one to which we defer.").

The bodies responsible for accrediting medical schools likewise recognize the important role that student diversity plays in the effective delivery of health care. In its *Standards for Accreditation*, the LCME evaluates whether

> [a] medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

Standards for Accreditation, *supra*, at 4 (Standard 3.3).

Other accrediting organizations for health professional programs have adopted similar standards. The Commission on Osteopathic College Accreditation advises: "A diverse student body provides the richness necessary for osteopathic medical education. A [school] should make every effort to recruit students from a diverse background to foster that

richness while meeting its mission and objectives." Comm'n on Osteopathic Coll. Accreditation, *Accreditation of Colleges of Osteopathic Medicine: COM Accreditation Standards and Procedures*, at 18 (2015) (www.osteopathic.org/inside-aoa/accreditation/predoctoral%20accreditation/Documents/COM-accreditation-standards-current.pdf) (Guideline to Rule 5.3.2).

The Commission on Dental Accreditation has similarly recognized that "the demographics of our society are changing," and that "[d]iversity in education is essential to academic excellence." Comm'n on Dental Accreditation, *Accreditation Standards for Dental Education Programs*, at 12, 16 (2015) (www.ada.org/~/media/CODA/Files/predoc.ashx). Echoing the importance of cultural competence in the medical profession, the most recent standards emphasize the role of classroom diversity in achieving this goal:

> A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, religions, and backgrounds; come from cities, rural areas and from various geographic regions; and have a wide variety of interests, talents, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively homogenous environment. Programs must create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines.

Id. at 16.

These standards, like those adopted by other accrediting bodies, are not (as some have incorrectly argued)[4] directives to schools to implement any particular form of diversity policies. The standards do not define diversity. Instead, the LCME and other accrediting organizations defer to each individual school with respect to what types and levels of diversity are best suited to achieve the mission and goals of that particular institution. None of these organizations has promoted a specific form of diversity, and yet all emphasize the vital role that it plays in educating and training health care professionals. Prohibiting medical educators from valuing and achieving diversity would harm both students and the broader society that they are being trained to serve.

II. MEDICAL SCHOOLS HAVE LONG RELIED ON HOLISTIC REVIEW FOR ADMISSIONS DECISIONS.

Because consideration of grades and test scores alone is insufficient in selecting a student body that will achieve a school's distinct educational goals and mission, most medical schools have adopted a holistic review process similar to that upheld by this Court in *Grutter*. Holistic review is a flexible, highly-individualized consideration of the multiple ways in which medical school applicants can demonstrate merit by matching an institution's mission. "Under a holistic review framework, candidates are evaluated by criteria that are institution-specific, broad-based, and mission-driven and that are applied equitably across the entire candidate pool." Addams et al.,

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[4] *See* Heriot Amicus Br. at 14–15; Cal. Ass'n of Scholars Amicus Br. at 14–15.

supra, at ix. Since well before *Grutter*, most medical schools have used at least some form of highly-individualized review in the admissions process that considers the many dimensions of merit, and potential contributions to the learning environment, of each candidate.

A. Medical Schools Have A History Of Highly-Individualized Admissions Practices.

The qualities that contribute to a successful health care professional are impossible to measure with grades and test scores alone. "Medical educators agree that success in medical school requires more than academic competence; it also requires integrity, altruism, self-management, interpersonal and team-work skills, among other characteristics." Dana Dunleavy et al., *Medical School Admissions: More than Grades and Test Scores*, 11 Analysis in Brief No. 6, at 1 (AAMC Sept. 2011) (footnotes omitted). To assess these qualities, medical schools have a long history of highly-individualized admissions processes, including personal pre-admission interviews for every accepted applicant.

Although these processes vary with the educational mission and goals of each school, all medical schools consider a range of non-academic factors. *Id.* Medical schools have never exclusively relied on numerical criteria to select their student bodies. *See* Filo Maldonado, *Rethinking the Admissions Process: Evaluation Techniques That Promote Inclusiveness in Admissions Decisions*, in *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions* 305–07 (Inst. of Med. 2001). While undergraduate GPA and MCAT scores are usually high on the list of considerations in

determining which applicants to interview, medical schools rank personal interviews and, to a lesser extent, letters of recommendation as the most important considerations in final acceptance decisions. Dunleavy et al., *supra*, at 2. In fact, between 2012 and 2014, 8.8% of applicants with the highest combined GPAs and MCAT scores were *rejected* by *all* of the medical schools to which they applied. *See* AAMC, *MCAT and GPA Grid for Applicants and Acceptees to U.S. Medical Schools, 2012-2014 (aggregated)* (2014) (www.aamc.org/download/321508/data/factstable24.pdf) (table 24).

Holistic review precludes any single criterion from becoming the uniform deciding factor for interviewing and selecting candidates for admission. Serious consideration is afforded to the ways in which each applicant might uniquely contribute to a diverse educational environment and advance the school's specific mission. A recent survey of health professional schools tied holistic review to the following institution-specific missions: serving underserved rural communities, serving underserved urban communities, research, primary care, and global health. *See* Urban Univs. for HEALTH, *Holistic Admissions in the Health Professions* 20 (Sept. 2014) (http://urbanuniversitiesforhealth.org/media/documents/Holistic_Admissions_in_the_Health_Professions.pdf). Each candidate is able to communicate his or her potential as more than a set of numbers, and, through holistic review, medical schools are able to consider these factors in light of the institutional goals for the classroom, clinical practice, and biomedical research. *See* Addams et al., *supra*, at x. This holistic consideration of applicants is precisely

the reason that individual interviews are so vital to the medical school admissions process.

For some schools, the range of factors considered during holistic review may include race, ethnicity, and gender. However, these factors are only considered to the extent necessary to achieve clearly articulated mission-driven benefits. *Id.* at 6. To the extent that race is considered, it is never considered in isolation. Health professional schools assess the following non-academic criteria through holistic review: status as a first-generation college student, experience with disadvantaged populations, socioeconomic status, origin in a community that is medically underserved, origin in a geographic area specifically targeted by the school, race/ethnicity (if permitted by state law), and foreign language ability. *See Holistic Admissions in the Health Professions*, *supra*, at 19. Race is considered flexibly as just one of the many characteristics and pertinent elements of each individual's background. Characteristics that make an individual particularly well-suited for the medical profession, such as resilience or the ability to overcome challenges, may in some cases be intertwined with an individual's race or ethnicity. When candidates have overcome great race-related challenges, obscuring or denying the realities of these challenges will hinder a full appreciation of the applicant's potential contributions.

For most schools, there is no substitute for the consideration of an individual's racial identity and ethnic background as part of the holistic review process intended to ensure that health professionals are educated in a diverse environment. As the Court indicated in *Grutter*, "percentage plans," such as the one used by respondent for undergraduate admis-

sions, do not translate to the professional school environment. *See Grutter*, 539 U.S. at 340 ("The United States does not * * * explain how such plans could work for graduate and professional schools. Moreover, even assuming such plans are race-neutral, they may preclude the university from conducting the individualized assessments necessary to assemble a student body that is not just racially diverse, but diverse along all the qualities valued by the university."). Most medical schools draw from a nationwide (and often worldwide) applicant pool that makes it impossible to make simple comparisons based on grade point averages. And, as noted, such comparisons do not begin to capture the range of qualities that schools have always considered.

Moreover, medical schools have expressly relied on this Court's pronouncements in crafting their holistic review procedures. After the Court's decision in *Grutter*, the AAMC convened an Advisory Committee on Holistic Review, a constituent working group, to address how to increase diversity among health professional students in alignment with the framework upheld by the Court. The Advisory Committee began developing tools and resources, such as the *Roadmap* guidance documents discussed above, that medical schools could adopt or adapt to create and sustain student diversity through the use of holistic review in the admissions process. Using these tools, the AAMC has conducted cross-country workshops with more than 60 medical schools, osteopathic schools, and nursing schools. The AAMC's commitment to assisting schools in crafting institution-specific diversity policies in the context of a legally-sound holistic review process is ongoing, with the recent addition of a third *Roadmap*

guidance document on self-evaluation of admissions practices and policies.

Medical schools do not use the Court's approved holistic review framework as a substitute for merit-based consideration of medical school applicants. Rather, it is a process through which medical schools are better able to appreciate the individual merits of each candidate to be a successful student and, ultimately, physician. One medical school reports that students admitted through holistic review are at least as well prepared academically as students admitted prior to the implementation of holistic review (the average GPA and average MCAT score were 3.66 and 33.62 for the entering class of 2012, as compared with 3.57 and 31.68 for the entering class of 2008). Witzburg & Sondheimer, *supra*, at 1567. This finding tracks those reported in a recent survey of public schools of medicine, dentistry, nursing, pharmacy, and public health using holistic review in admissions: 90% of the schools reported that the average GPA of incoming classes either remained unchanged or increased; 89% reported that average standardized test scores either remained unchanged or increased; 96% reported that graduation rates were either unchanged or increased; and 91% reported that the average number of attempts for students to pass required licensing exams either remained unchanged or improved. *See Holistic Admissions in the Health Professions*, *supra*, at 14.

B. Although Other Initiatives Have Shown Some Success, It Remains Necessary For Medical Schools To Consider Applicants' Full Backgrounds In Order To Achieve The Schools' Educational Goals.

Consistent with the requirements of narrow tailoring, direct consideration of race is to be continued only as necessary. Medical schools are implementing a host of initiatives outside of the admissions context to help achieve a diverse and culturally-competent student body and physician workforce. Those initiatives have had success in increasing the diversity of the medical school applicant pool. But this success has not been universal and such initiatives are not the complete answer. In order to discharge their obligations to produce well-trained health professionals who are prepared to serve all of society, many medical schools continue to find it necessary to consider an applicant's entire background, including race or ethnicity as one factor among many.

"Pipeline" programs, which seek to encourage and prepare underrepresented minorities to pursue a medical education, have had promising results. For example, the Robert Wood Johnson Foundation has funded the Summer Medical and Dental Education Program ("SMDEP") and its predecessor programs to increase diversity in the health professions for over 25 years. This program is currently implemented at 12 medical and 9 dental schools across the United States, serving 960 minority and socio-economically disadvantaged college students each year. To date, it has served over 23,000 aspiring health professionals. A 2015 study found that SMDEP increases the likelihood that students from diverse backgrounds

will apply and matriculate to both medical and dental school. *See* Clemencia Cosentino et al., *Impact Evaluation of the RWJF Summer Medical and Dental Education Program (SMDEP)*, at x (Mathematica Jan. 28, 2015) (www.mathematica-mpr.com/our-publications-and-findings/publications/impact-evaluation-of-the-rwjf-summer-medical-and-dental-education-program-smdep).

Additional studies from smaller programs also demonstrate success in encouraging younger students to pursue the health professions. *See, e.g.*, Behnoosh Afghani et al., *A Novel Enrichment Program Using Cascading Mentorship to Increase Diversity in the Health Care Professions*, 88 Acad. Med. 1232 (2013). And a recent study found that physicians who graduated from postbaccalaureate programs which help promising college graduates from disadvantaged and underrepresented backgrounds get into and succeed in medical school were "significantly more likely to be providing care in settings that enable access to health care services for underserved and vulnerable populations" than a comparison physician group. Leon McDougle et al., *A National Long-term Outcomes Evaluation of U.S. Premedical Postbaccalaureate Programs Designed to Promote Health care Access and Workforce Diversity*, 26 J. Health Care for Poor & Underserved 631, 639–40 (2015).

Medical schools have also invested in recruitment and outreach strategies that are designed to increase the number of underrepresented minority applicants and matriculants. For example, the USSTRIDE program at Florida State University, which provides academic and social support services and mentoring to college students, found that Black and Latino

participants had higher medical school acceptance rates than a comparison group. *See* Kendall M. Campbell et al., *USSTRIDE Program is Associated with Competitive Black and Latino Student Applicants to Medical School*, Med. Educ. Online (May 2014). And the University of Chicago Pritzker School of Medicine has found that having a focus in the medical school curriculum on health disparities among underrepresented minorities correlated with a significant increase in accepted underrepresented minorities deciding to matriculate. *See* Monica B. Vela et al., *Improving Underrepresented Minority Medical Student Recruitment with Health Disparities Curriculum*, 25 J. Gen. Intern. Med. S82, S83–85 (Supp. 2 2010).

At the same time, systemic changes are also being made in the medical education system to address concerns about cultural competence in health care. For example, the AAMC and the Association of Schools and Programs of Public Health ("ASPPH") have published joint recommendations for training medical and public health students to become more culturally competent practitioners. *See* AAMC & ASPPH, *Cultural Competence Education for Students in Medicine and Public Health* (July 2012) (members.aamc.org/eweb/upload/Cultural%20Competence%20Education_revisedl.pdf). AAMC has also worked to develop a new MCAT exam, which was introduced in 2015 and is designed in part to measure how well an applicant understands the cultural, social, and socio-economic differences that can influence health.

While many of these programs and efforts are helpful, on their own they are insufficient. Due to a multitude of factors outside of medical schools' influence or control, including economic forces, the past

decade has only seen a slight increase in the percentages of underrepresented minorities nationwide that apply to medical school. *See* AAMC, *Race/Ethnicity of Applicants to U.S. Medical Schools, 2013-2014 and 2014-2015* (2014) (www.aamc.org/download/321484/data/factstable13.pdf) (table 13). A recent study highlighted that among high school students expressing an interest in becoming a physician, those who change their minds are disproportionately from the groups least represented in medicine. *See* Emory Morrison & David A. Cort, *An Analysis of the Medical School Pipeline: A High School Aspirant to Applicant and Enrollment View*, 14 Analysis in Brief No. 3, at 2 (AAMC Mar. 2014).

Indeed, while many initiatives and programs supported by foundations, medical schools, and government have contributed to increasing diversity in the physician pipeline, the number of applicants from one major demographic group—black males—has not increased above the number from 1978, when *Bakke* was decided. That year, 1,410 black males applied to medical school, and in 2014, just 1,337 applied. A similar trend is observed for first-time matriculants. In 1978, there were 542 black male matriculants to M.D.-granting institutions; in 2014, there were 515. *See* AAMC, *Altering the Course: Black Males in Medicine*, at 4 (2015) (www.aamc.org/download/439660/data/20150803_alteringthecourse.pdf). This downward trend among black males occurred while the overall number of applicants and matriculants to medical schools increased, during that same period, from 36,626 and 16,054, respectively, to 49,480 and 20,343. *See* AAMC, *2015 Data Book*, at 17–18 (2015).

It does not appear that the under-representation of minority medical students can be rectified by assessing applicants based on proxy criteria such as economic disadvantage. For example, simply focusing on statistical information that correlates with disadvantage—such as low socio-economic status—will in all likelihood reduce rather than increase the number of underrepresented minority applicants accepted for admission. *See* Ann Steinecke et al., *Race-Neutral Admission Approaches: Challenges and Opportunities for Medical Schools*, 82 Acad. Med. 117, 123 (2007); William G. Bowen & Derek Bok, *The Shape of the River* 270–71 (1998). And any prohibition on the consideration of race in student admissions will result in a student body with significantly fewer underrepresented minority students. *See* Liliana M. Garces & David Mickey-Pabello, *Racial Diversity in the Medical Profession: The Impact of Affirmative Action Bans on Underrepresented Student of Color Matriculation in Medical Schools*, 86 J. of Higher Ed. 264, 287 (2015) (finding that affirmative action bans in six states resulted in a 17% decline in first-time matriculation of medical school students who are underrepresented students of color).

Medical educators continue to find that a deliberate focus on fostering diversity in medical education is essential if medical schools are to fulfill their responsibility to effectively serve all of society. It is hoped that such actions will no longer be necessary in the future, but that future has not yet arrived.

III. PRECLUDING OR LIMITING HOLISTIC REVIEW WOULD DISRUPT ADMISSIONS PRACTICES CRAFTED IN RELIANCE UPON THE COURT'S PRECEDENTS.

For more than thirty-five years, the Nation's medical schools have utilized the kind of holistic admissions process approved by the Court's holdings in *Bakke* and *Grutter*. In the schools' expert judgments, such practices are necessary to train physicians and other leaders in the health professions who can effectively serve an increasingly diverse society. Health professional educators have faithfully abided by the Court's guidance, including in *Fisher I*. *See, e.g.*, Coleman et al., *supra* (2014 revisions to AAMC *Roadmap* guidance document). Amici urge the Court not to disrupt that reliance by withdrawing its imprimatur from those longstanding practices.

In no event should the Court accept the arguments of some of petitioners' amici—but not petitioner herself—that *Grutter* should be overruled. The Court's commitment to *stare decisis* "promotes the evenhanded, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." *Payne* v. *Tennessee*, 501 U.S. 808, 827 (1991). "Indeed, the very concept of the rule of law underlying our own Constitution requires such continuity over time that a respect for precedent is, by definition, indispensable." *Planned Parenthood of SE Pa.* v. *Casey*, 505 U.S. 833, 854 (1992) (citing Lewis F. Powell, Jr., *Stare Decisis and Judicial Restraint*, 1991 J. Sup. Ct. Hist. 13, 16 (1991)).

Stare decisis should be respected here. Far from "defying practical workability," *id.* at 854, the holistic

admissions process approved in *Grutter* and *Bakke* continues to be the predominant mode of decision making employed by universities and graduate schools across the Nation. Those schools, moreover, have expressly relied on this Court's precedents in doing so. As the Court remarked in *Grutter*, "[p]ublic and private universities across the Nation have modeled their own admissions programs on Justice Powell's views." 539 U.S. at 323. That reliance has only grown in the more than twelve years since the full Court endorsed Justice Powell's reasoning. *See supra* at 27–28. And there are no new facts that "have robbed [*Grutter*'s] rule of significant application or justification." *Casey*, 505 U.S. at 855. Quite the opposite, the need for educators to value diversity in education has only increased as our Nation has become more diverse.

For her part, petitioner insists on a narrow concept of diversity. She contends that respondent's "Top 10%" law achieves sufficient levels of diversity—measured solely by demographic statistics—such that the holistic review approved in *Grutter* could never be justified for any of respondent's admissions decisions. To the extent petitioner is arguing that holistic review should be jettisoned in favor of a process that focuses exclusively on class rank, grades, and test scores, that argument should be rejected. Indeed, as noted above, reliance on a mechanical process like a Top 10% plan is not workable for medical schools, and medical educators have always relied on far more than grades and test scores to achieve their goal of training the next generation of physicians and other health care professionals. *See supra* at 24–27.

Unlike most undergraduate institutions, medical and other health professional schools have always considered and highly value personal interviews in order to learn what the applicant's background would contribute to a culturally competent workforce. Removing the ability of medical schools to consider applicants' race and ethnicity as one of many personal attributes would undermine their ability to assess the entirety of each individual's background, thus frustrating the goal of best serving the public's health. At a time when our Nation is becoming more diverse, and health disparities remain so stark, constraining a medical school's ability to consider a student's entire background would negatively impact not only the classroom, but also patients, who would be deprived of a pipeline of physicians better equipped through personal experience and a diverse learning environment to understand and serve patients from all walks of life.

It is difficult, if not impossible, to insulate consideration of an applicant's race or ethnicity from consideration of the rest of that individual's background. Where an admissions process includes reliance on personal statements, for example, ignoring race and ethnicity "might not even be possible," since "to read the file in a 'colorblind' way, the admissions officer would likely have to ignore highly relevant information, without which the applicant's personal statement might literally not make sense." Devon W. Carbado & Cheryl I. Harris, *The New Racial Preferences*, 96 Cal. L. Rev. 1139, 1146–47, 1149 (2008). Similarly, requiring applicants to exclude any references to their race or ethnicity "create[s] an incentive for applicants to suppress their racial identity and to adopt the

position that race does not matter in their lives," which "is likely to be particularly costly to applicants for whom race is a central part of their social experience and sense of identity." *Id.* at 1148.

Holistic review in medical school admissions is not a static concept. Rather, continuously "[e]valuating the effectiveness of admission policies, processes, and criteria in producing outcomes that reflect a medical school's mission is a core element of holistic review." Addams et al., *supra*, at 21. In furtherance of that principle, medical schools constantly re-evaluate their admissions processes to align them with the fundamental objectives of producing physicians of the highest caliber who can meet the health needs of the entire population. Given the persistence of health disparities among minority communities and the unconscious bias that contributes to that problem, amici strongly believe that it remains necessary in 2015 for institutions to continue to take action to ensure diversity in the admissions process. Our judgment about necessity reflects careful consideration of the responsibility our educational institutions have in preparing a healthcare workforce to meet the health needs of a diverse population, and is anything but "routine." Pet. Br. at 48. Amici believe that it would be a grave mistake for this Court to upset decades of precedent by precluding or significantly reducing the ability of expert medical educators to ensure that the next generation of physicians and other health professionals is educated and trained in an environment that will prepare them to address the Nation's critical health needs.

CONCLUSION

For the foregoing reasons, and those in respondents' brief, the judgment below should be affirmed.

Respectfully submitted,

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ADDENDUM

AMICI CURIAE

Association of American Medical Colleges—represents all 145 accredited U.S. medical schools, nearly 400 teaching hospitals and health systems, and 90 academic and scientific societies.

American Academy of Family Physicians—represents 120,900 family physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States.

American Academy of Pediatrics—represents 64,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists who are committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.

American Academy of Physician Assistants—represents approximately 104,000 certified physician assistants in the United States and provides advocacy and educational benefits on behalf of the profession and the patients served by physician assistants.

American Association of Colleges of Nursing—represents 768 institutions offering baccalaureate and graduate programs in nursing.

American Association of Colleges of Osteopathic Medicine—represents the 31 accredited colleges of osteopathic medicine in the United States, which deliver instruction at 44 teaching locations in 29 states.

American Association of Colleges of Pharmacy—represents pharmacy education in the United States, advancing pharmacy education,

research, scholarship, practice, and service to improve societal health.

American College of Obstetricians and Gynecologists—represents more than 57,000 physicians who specialize in the health care of women.

American College of Physicians—represents 143,000 internal medicine physicians (internists), related subspecialists, and medical students.

American Dental Association—represents the interests of its 157,000 members, advocates for the public's oral health, and promotes the dental health profession in all 50 states, the District of Columbia, and Puerto Rico.

American Dental Education Association—represents all 66 U.S. dental schools and 10 Canadian dental schools.

American Medical Association—the largest professional association of physicians, residents, and medical students in the United States.

American Medical Student Association—represents the concerns of more than 40,000 physicians-in-training in the United States.

American Nurses Association—represents the interests of 3.4 million registered nurses, has more than 179,000 members through both state associations and individual membership, and has 35 national organizational affiliates that collectively represent approximately 420,000 registered nurses in specialty areas.

American Osteopathic Association—represents more than 122,000 osteopathic physicians ("DOs") and osteopathic medical students, promotes public

health, encourages scientific research, serves as the primary certifying body for DOs and the accrediting agency for osteopathic medical schools, and has federal authority to accredit hospitals and other health care facilities.

American Psychiatric Association—represents more than 36,000 physicians specializing in psychiatry who are engaged in treatment, research, and the education of physicians.

American Public Health Association—champions the health of all people and all communities, strengthens the profession of public health, shares the latest research and information, promotes best practices, and advocates for public health issues and policies grounded in research.

Associated Medical Schools of New York—represents the 16 medical schools in New York State.

Association of Academic Health Centers—a non-profit association dedicated to advancing the Nation's health and well-being through the vigorous leadership of academic health centers.

Association of American Indian Physicians—committed to pursue excellence in Native American health care by promoting education in medical disciplines and honoring traditional cultural principles, and by offering educational programs, services, and activities to motivate American Indian/Alaska Native students to pursue careers in health professions and/or biomedical research.

Association of American Veterinary Medical Colleges—represents all 30 accredited colleges and schools of veterinary medicine in the U.S.

Association of Schools of Allied Health Professions—a national association comprised of 115 not-for-profit universities focused on issues impacting allied health education.

Association of Schools and Programs of Public Health—represents more than 100 schools and programs accredited by the Council on Education for Public Health.

Association of University Programs in Health Administration—a global network of colleges, universities, faculty, individuals, and organizations dedicated to the improvement of health and healthcare delivery through excellence in healthcare management and policy education and scholarship.

National Association of Hispanic-Serving Health Professions Schools, Inc.—represents 43 schools of medicine, public health, nursing, pharmacy, and dentistry that strive to strengthen the Nation's capacity to increase the Hispanic health workforce and advance the health of Hispanics.

National Hispanic Health Foundation—a 501(c)(3) non-profit philanthropic arm of the National Hispanic Medical Association with the mission to provide education and research activities to improve the health of Hispanics.

National Hispanic Medical Association—represents the interests and concerns of 50,000 licensed physicians committed to the mission to improve the health of Hispanic populations with affiliated Hispanic medical societies, resident and medical student organizations, and other public and private partners.

National Medical Association—represents and promotes the interests of physicians and patients of African descent.

National Medical Fellowships, Inc.—provides scholarships for underrepresented minorities in medicine and the health professions.

Physician Assistant Education Association—represents over 200 physician assistant programs across the Nation.

Society of General Internal Medicine—represents more than 3,600 of the world's leading academic general internists, who are dedicated to improving access to care for vulnerable populations, eliminating health care disparities, and enhancing medical education.

Student National Medical Association—represents more than 6,000 medical students, premedical students, residents, and physicians committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent, and socially conscious physicians.

The ASPIRA Association, Inc.—promotes the education and leadership development of Puerto Rican and other Latino youth, and works with over 50,000 youth and their families each year.